STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX **File No. 89384-001**
Petitioner
v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 3rd day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 24, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the material submitted and accepted the request on May 1, 2008.

The Commissioner assigned the case to an independent review organization (IRO) because it involved medical issues. The IRO provided its analysis and recommendations to the Commissioner on May 23, 2007.

II
FACTUAL BACKGROUND

The Petitioner receives health care benefits from Blue Cross Blue Shield of Michigan (BCBSM) under its *Professional Services Group Benefits Certificate* (the certificate).

The Petitioner has been diagnosed with gender identity disorder. On August 17, 2007, he underwent sex-reassignment surgery (female to male). His surgeon, XXXXX, located in XXXXX, XXXXX, does not participate with BCBSM or a local Blue Cross Blue Shield plan in XXXXX. The Petitioner paid the full $18,645.00 charged by the surgeon. A claim for XXXXX services was submitted to BCBSM using procedure code (PC) 55980 (inter-sex surgery; female to male).[1]

BCBSM determined, after a review of the medical records, that PC 55980 was not documented. BCBSM decided that that the procedure code that best described the procedure performed by XXXXX is PC 53430 (urethroplasty, reconstruction of female urethra). BCBSM paid $1,263.04 to the Petitioner, its maximum amount for PC 53430.

The Petitioner appealed BCBSM's payment for XXXXX's services. After a managerial-level conference on January 24, 2008, BCBSM's medical consultants concluded that an increase of 35% was warranted for XXXXX's services and the Petitioner was paid an additional $442.10. The total amount paid for XXXXX's services was $1,705.14.

The Petitioner exhausted BCBSM's internal grievance process and received its final adverse determination dated February 26, 2008, documenting the additional payment. The Petitioner was not satisfied with the additional amount BCBSM paid and requested an external review by the Commissioner.

III
ISSUE

Did BCBSM properly pay for the surgical services provided the Petitioner by XXXXX on August 14, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner indicated that BCBSM's denial of additional payment for his August 14, 2007

1 Other procedures were also performed that day but they were done by participating providers.

surgery was based on an alleged incorrect use of PC 55980 (BCBSM believed the operative report was not in accord with the definition of PC 55980). But the Petitioner says another member of the surgical team used this same procedure code and was reimbursed by BCBSM for his services.

The Petitioner believes that the surgical service provided by XXXXX was approved by BCBSM and that if BCBSM will not recognize this care under PC 55980 then it should recreate a related code. The Petitioner believes BCBSM should pay a much greater amount for this care.

The Petitioner points out that sex-reassignment surgery is relatively rare and there is a limited pool of surgeons to choose from. He notes that it is much more difficult to find a BCBSM-participating surgeon to perform these services than it is to find a participating cardiologist or oncologist and that a patient has very little choice if he or she wants a medically safe, psychologically effective, and anatomically functional result.

The Petitioner believes that BCBSM should consider these circumstances and be required to pay significantly more for the care provided by XXXXX.

BCBSM's Argument

BCBSM says the certificate states (page 2.21) that "We [BCBSM] pay the approved amount for each medically necessary covered service." The certificate does not guarantee that charges will be paid in full; rather the payments are based on the lesser of the provider's charge or BCBSM's maximum payment level.

In determining the payment level for each service, BCBSM applies a Resource Based Relative Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, including physician

time, specialty training, malpractice premiums, practice expenses, and overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice.

BCBSM's payment levels for surgical procedures include consideration of extenuating circumstances which affect the length of time required to perform a specific procedure. Individual consideration is given when complications arise and additional steps or procedures are necessary.

BCBSM says that the procedure code that best describes XXXXX's surgery was PC 53430, not 55980, and therefore it reimbursed the Petitioner $1,263.04, the maximum payment level for PC 53430. BCBSM also did a second review of the medical records and its medical consultant determined that the XXXXX's surgery was a "redo" procedure which justified an additional 35% reimbursement of $442.10. With this additional payment, BCBSM has paid a total of $1,705.14 for XXXXX's services which it believes is the proper amount for this care.

The Petitioner argued that another member of his surgical team was paid for performing PC 55980 but BCBSM says that payment was made in error and would be adjusted.

Commissioner's Review

The Petitioner's certificate explains how benefits are paid. It says that BCBSM pays its approved amount for a covered service. It also states on page 2.22:

> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

XXXXX billed the Petitioner for his services using PC 55980. BCBSM did not believe that the operative notes reflected that procedure and it reimbursed the Petitioner for the claim using PC 53430. The question of whether the Petitioner's claim was paid under the correct procedure code and if additional payment for these services is warranted was presented to an IRO for analysis as required by section 11(6) of PRIRA, MCL 550.1911(6). The IRO physician reviewer is board certified in urology, holds an academic appointment, and has been in active practice for more than ten years.

The IRO physician reviewed the medical records related to the Petitioner's August 14, 2007, surgery and the IRO report says:

> The XXXXX physician consultant explained that a review of the operative report from this surgery did not reveal any additional complexity or other unusual factors. The XXXXX physician consultant also explained that [BCBSM's] coding of this procedure was appropriate. The XXXXX physician consultant indicated that no additional reimbursement is warranted for this procedure based upon the information provided for review.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case.

The Commissioner accepts the conclusion of the IRO and finds that no additional reimbursement is warranted for the surgical services provided the Petitioner on August 14, 2007. With the additional payment of $442.10, BCBSM has paid its approved amount for XXXXX's services.

V
ORDER

Respondent BCBSM's February 26, 2008, final adverse determination is upheld. BCBSM is not required to pay an additional amount for the Petitioner's August 14, 2007, surgery.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.